General Assembly **Amendment**

January Session, 2007 LCO No. **9216**

SB0000109216SD0

Offered by:
SEN. WILLIAMS, 29th Dist.
REP. AMANN, 118th Dist.

To: Subst. Senate Bill No. **1** File No. 472 Cal. No. 358

"AN ACT CONCERNING THE HEALTHFIRST CONNECTICUT INITIATIVE."

Strike everything after the enacting clause and substitute the following in lieu thereof:

"Section 1. Section 17b-28e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) Not later than September 30, 2002, the Commissioner of Social Services shall submit an amendment to the Medicaid state plan to implement the provisions of public act 02-1 of the May 9 special session* concerning optional services under the Medicaid program. Said state plan amendment shall supersede any regulations of Connecticut state agencies concerning such optional services.

(b) The Commissioner of Social Services shall amend the Medicaid state plan to include foreign language interpreter services provided to any beneficiary with limited English proficiency as a covered service

under the Medicaid program.

Sec. 2. Section 17b-192 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) The Commissioner of Social Services shall implement a state medical assistance component of the state-administered general assistance program for persons ineligible for Medicaid. **[**Not later than October 1, 2003, each**]** Eligibility criteria concerning income shall be the same as the medically needy component of the Medicaid program, except that earned monthly gross income of up to one hundred fifty dollars shall be disregarded. Unearned income shall not be disregarded. No person who has family assets exceeding one thousand dollars shall be eligible. No person shall be eligible for assistance under this section if such person made, during the three months prior to the month of application, an assignment or transfer or other disposition of property for less than fair market value. The number of months of ineligibility due to such disposition shall be determined by dividing the fair market value of such property, less any consideration received in exchange for its disposition, by five hundred dollars. Such period of ineligibility shall commence in the month in which the person is otherwise eligible for benefits. Any assignment, transfer or other disposition of property, on the part of the transferor, shall be presumed to have been made for the purpose of establishing eligibility for benefits or services unless such person provides convincing evidence to establish that the transaction was exclusively for some other purpose.

(b) Each person eligible for state-administered general assistance shall be entitled to receive medical care through a federally qualified health center or other primary care provider as determined by the commissioner. The Commissioner of Social Services shall determine appropriate service areas and shall, in the commissioner's discretion, contract with community health centers, other similar clinics, and other primary care providers, if necessary, to assure access to primary care services for recipients who live farther than a reasonable distance

from a federally qualified health center. The commissioner shall assign and enroll eligible persons in federally qualified health centers and with any other providers contracted for the program because of access needs. **[**Not later than October 1, 2003, each**]** Each person eligible for state-administered general assistance shall be entitled to receive hospital services. Medical services under the program shall be limited to the services provided by a federally qualified health center, hospital, or other provider contracted for the program at the commissioner's discretion because of access needs. The commissioner shall ensure that ancillary services and specialty services are provided by a federally qualified health center, hospital, or other providers contracted for the program at the commissioner's discretion. Ancillary services include, but are not limited to, radiology, laboratory, and other diagnostic services not available from a recipient's assigned primary-care provider, and durable medical equipment. Specialty services are services provided by a physician with a specialty that are not included in ancillary services. In no event shall ancillary or specialty services provided under the program exceed such services provided under the state-administered general assistance program on July 1, 2003. **[**Eligibility criteria concerning income shall be the same as the medically needy component of the Medicaid program, except that earned monthly gross income of up to one hundred fifty dollars shall be disregarded. Unearned income shall not be disregarded. No person who has family assets exceeding one thousand dollars shall be eligible. No person eligible for Medicaid shall be eligible to receive medical care through the state-administered general assistance program. No person shall be eligible for assistance under this section if such person made, during the three months prior to the month of application, an assignment or transfer or other disposition of property for less than fair market value. The number of months of ineligibility due to such disposition shall be determined by dividing the fair market value of such property, less any consideration received in exchange for its disposition, by five hundred dollars. Such period of ineligibility shall commence in the month in which the person is otherwise eligible for benefits. Any assignment, transfer or other disposition of property, on

the part of the transferor, shall be presumed to have been made for the purpose of establishing eligibility for benefits or services unless such person provides convincing evidence to establish that the transaction was exclusively for some other purpose.**]**

[(b) Recipients covered by a general assistance program operated by a town shall be assigned and enrolled in federally qualified health centers and with any other providers in the same manner as recipients of medical assistance under the state-administered general assistance program pursuant to subsection (a) of this section.**]**

(c) **[**On and after October 1, 2003, pharmacy**]** Pharmacy services shall be provided to recipients of state-administered general assistance through the federally qualified health center to which they are assigned or through a pharmacy with which the health center contracts. **[**Prior to said date, pharmacy services shall be provided as provided under the Medicaid program.**]** Recipients who are assigned to a community health center or similar clinic or primary care provider other than a federally qualified health center or to a federally qualified health center that does not have a contract for pharmacy services shall receive pharmacy services at pharmacies designated by the commissioner. The Commissioner of Social Services or the managed care organization or other entity performing administrative functions for the program as permitted in subsection (d) of this section, shall require prior authorization for coverage of drugs for the treatment of erectile dysfunction. The commissioner or the managed care organization or other entity performing administrative functions for the program may limit or exclude coverage for drugs for the treatment of erectile dysfunction for persons who have been convicted of a sexual offense who are required to register with the Commissioner of Public Safety pursuant to chapter 969.

(d) The Commissioner of Social Services shall contract with federally qualified health centers or other primary care providers as necessary to provide medical services to eligible state-administered general assistance recipients pursuant to this section. The

commissioner shall, within available appropriations, make payments to such centers based on their pro rata share of the cost of services provided or the number of clients served, or both. The Commissioner of Social Services shall, within available appropriations, make payments to other providers based on a methodology determined by the commissioner. The Commissioner of Social Services may reimburse for extraordinary medical services, provided such services are documented to the satisfaction of the commissioner. For purposes of this section, the commissioner may contract with a managed care organization or other entity to perform administrative functions, including a grievance process for recipients to access review of a denial of coverage for a specific medical service, and to operate the program in whole or in part. Provisions of a contract for medical services entered into by the commissioner pursuant to this section shall supersede any inconsistent provision in the regulations of Connecticut state agencies. A recipient who has exhausted the grievance process established through such contract and wishes to seek further review of the denial of coverage for a specific medical service may request a hearing in accordance with the provisions of section 17b-60.

(e) Each federally qualified health center participating in the program shall **[**, within thirty days of August 20, 2003,**]** enroll in the federal Office of Pharmacy Affairs Section 340B drug discount program established pursuant to 42 USC 256b to provide pharmacy services to recipients at Federal Supply Schedule costs. Each such health center may establish an on-site pharmacy or contract with a commercial pharmacy to provide such pharmacy services.

(f) The Commissioner of Social Services shall, within available appropriations, make payments to hospitals for inpatient services based on their pro rata share of the cost of services provided or the number of clients served, or both. The Commissioner of Social Services shall, within available appropriations, make payments for any ancillary or specialty services provided to state-administered general assistance recipients under this section based on a methodology determined by the commissioner.

(g) On or before **[**March 1, 2004**]** January 1, 2008, the Commissioner of Social Services shall seek a waiver of federal law **[**under the Health Insurance Flexibility and Accountability demonstration initiative**]** for the purpose of extending health insurance coverage under Medicaid to persons **[**qualifying**]** with income not in excess of one hundred per cent of the federal poverty level who otherwise qualify for medical assistance under the state-administered general assistance program. The provisions of section 17b-8 shall apply to this section.

(h) The commissioner, pursuant to section 17b-10, may implement policies and procedures to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of the intent to adopt the regulation in the Connecticut Law Journal not later than twenty days after the date of implementation. Such policy shall be valid until the time final regulations are adopted.

Sec. 3. Section 17b-261 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) Medical assistance shall be provided for any otherwise eligible person whose income, including any available support from legally liable relatives and the income of the person's spouse or dependent child, is not more than one hundred forty-three per cent, pending approval of a federal waiver applied for pursuant to subsection (d) of this section, of the benefit amount paid to a person with no income under the temporary family assistance program in the appropriate region of residence and if such person is an institutionalized individual as defined in Section 1917(c) of the Social Security Act, 42 USC 1396p(c), and has not made an assignment or transfer or other disposition of property for less than fair market value for the purpose of establishing eligibility for benefits or assistance under this section. Any such disposition shall be treated in accordance with Section 1917(c) of the Social Security Act, 42 USC 1396p(c). Any disposition of property made on behalf of an applicant or recipient or the spouse of an applicant or recipient by a guardian, conservator, person

authorized to make such disposition pursuant to a power of attorney or other person so authorized by law shall be attributed to such applicant, recipient or spouse. A disposition of property ordered by a court shall be evaluated in accordance with the standards applied to any other such disposition for the purpose of determining eligibility. The commissioner shall establish the standards for eligibility for medical assistance at one hundred forty-three per cent of the benefit amount paid to a family unit of equal size with no income under the temporary family assistance program in the appropriate region of residence. **[**, pending federal approval, except that the**]** Except as provided in section 17b-277, as amended by this act, the medical assistance program shall provide coverage to persons under the age of nineteen **[**up to one hundred eighty-five per cent of the federal poverty level without an asset limit. Said medical assistance program shall also provide coverage to persons under the age of nineteen**]** and their parents and needy caretaker relatives, who qualify for coverage under Section 1931 of the Social Security Act, with family income up to one hundred **[**fifty**]** eighty-five per cent of the federal poverty level without an asset limit. **[**, upon the request of such a person or upon a redetermination of eligibility.**]** Such levels shall be based on the regional differences in such benefit amount, if applicable, unless such levels based on regional differences are not in conformance with federal law. Any income in excess of the applicable amounts shall be applied as may be required by said federal law, and assistance shall be granted for the balance of the cost of authorized medical assistance. All contracts entered into on and after July 1, 1997, pursuant to this section shall include provisions for collaboration of managed care organizations with the Nurturing Families Network established pursuant to section 17a-56. The Commissioner of Social Services shall provide applicants for assistance under this section, at the time of application, with a written statement advising them of (1) the effect of an assignment or transfer or other disposition of property on eligibility for benefits or assistance, (2) the effect that having income that exceeds the limits prescribed in this subsection will have with respect to program eligibility, (3) the availability of HUSKY Plan, Part B health

insurance benefits for persons who are not eligible for assistance pursuant to this subsection or who are subsequently determined ineligible for assistance pursuant to this subsection, and **[**(2)**]** (4) the availability of, and eligibility for, services provided by the Nurturing Families Network established pursuant to section 17a-56.

(b) For the purposes of the Medicaid program, the Commissioner of Social Services shall consider parental income and resources as available to a child under eighteen years of age who is living with his or her parents and is blind or disabled for purposes of the Medicaid program, or to any other child under twenty-one years of age who is living with his or her parents.

(c) For the purposes of determining eligibility for the Medicaid program, an available asset is one that is actually available to the applicant or one that the applicant has the legal right, authority or power to obtain or to have applied for the applicant's general or medical support. If the terms of a trust provide for the support of an applicant, the refusal of a trustee to make a distribution from the trust does not render the trust an unavailable asset. Notwithstanding the provisions of this subsection, the availability of funds in a trust or similar instrument funded in whole or in part by the applicant or the applicant's spouse shall be determined pursuant to the Omnibus Budget Reconciliation Act of 1993, 42 USC 1396p. The provisions of this subsection shall not apply to special needs trust, as defined in 42 USC 1396p(d)(4)(A).

(d) The transfer of an asset in exchange for other valuable consideration shall be allowable to the extent the value of the other valuable consideration is equal to or greater than the value of the asset transferred.

(e) The Commissioner of Social Services shall seek a waiver from federal law to permit federal financial participation for Medicaid expenditures for families with incomes of one hundred forty-three per cent of the temporary family assistance program payment standard.

(f) To the extent permitted by federal law, Medicaid eligibility shall be extended for one year to a family that becomes ineligible for medical assistance under Section 1931 of the Social Security Act due to income from employment by one of its members who is a caretaker relative or due to receipt of child support income. A family receiving extended benefits on July 1, 2005, shall receive the balance of such extended benefits, provided no such family shall receive more than twelve additional months of such benefits.

(g) An institutionalized spouse applying for Medicaid and having a spouse living in the community shall be required, to the maximum extent permitted by law, to divert income to such community spouse in order to raise the community spouse's income to the level of the minimum monthly needs allowance, as described in Section 1924 of the Social Security Act. Such diversion of income shall occur before the community spouse is allowed to retain assets in excess of the community spouse protected amount described in Section 1924 of the Social Security Act. The Commissioner of Social Services, pursuant to section 17b-10, may implement the provisions of this subsection while in the process of adopting regulations, provided the commissioner prints notice of intent to adopt the regulations in the Connecticut Law Journal within twenty days of adopting such policy. Such policy shall be valid until the time final regulations are effective.

(h) The Commissioner of Social Services shall, to the extent permitted by federal law, or, pursuant to an approved waiver of federal law submitted by the commissioner, in accordance with the provisions of section 17b-8, impose the following cost-sharing requirements under the HUSKY Plan, on all parent and needy caretaker relatives with incomes exceeding one hundred per cent of the federal poverty level: (1) A twenty-five-dollar premium per month per parent or needy caretaker relative; and (2) a copayment of one dollar per visit for outpatient medical services delivered by an enrolled Medicaid or HUSKY Plan provider. The commissioner may implement policies and procedures necessary to administer the provisions of this subsection while in the process of adopting such policies and

procedures as regulations, provided the commissioner publishes notice of the intent to adopt regulations in the Connecticut Law Journal not later than twenty days after implementation. Policies and procedures implemented pursuant to this subsection shall be valid until the time final regulations are adopted.

(i) Medical assistance shall be provided, in accordance with the provisions of subsection (e) of section 17a-6, to any child under the supervision of the Commissioner of Children and Families who is not receiving Medicaid benefits, has not yet qualified for Medicaid benefits or is otherwise ineligible for such benefits because of institutional status. To the extent practicable, the Commissioner of Children and Families shall apply for, or assist such child in qualifying for, the Medicaid program.

(j) The Commissioner of Social Services shall provide Early and Periodic Screening, Diagnostic and Treatment program services, as required and defined as of December 31, 2005, by 42 USC 1396a(a)(43), 42 USC 1396d(r) and 42 USC 1396d(a)(4)(B) and applicable federal regulations, to all persons who are under the age of twenty-one and otherwise eligible for medical assistance under this section.

Sec. 4. Section 17b-277 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) The Commissioner of Social Services shall provide, in accordance with federal law and regulations, medical assistance under the Medicaid program to needy pregnant women **[**and children up to one year of age**]** whose families have an income **[**up to one hundred eighty-five**]** not exceeding two hundred fifty per cent of the federal poverty level.

(b) The commissioner shall expedite eligibility for appropriate pregnant women applicants for the Medicaid program. The process for making expedited eligibility determinations concerning needy pregnant women shall ensure that emergency applications for assistance, as determined by the commissioner, shall be processed no

later than twenty-four hours after receipt of all required information from the applicant, and that nonemergency applications for assistance, as determined by the commissioner, shall be processed no later than five calendar days after the date of receipt of all required information from the applicant.

(c) Presumptive eligibility for medical assistance shall be implemented for any uninsured newborn child born in a hospital in this state or a border state hospital, provided (1) the parent or caretaker relative of such child resides in this state, and (2) the parent or caretaker relative of such child authorizes enrollment in the program.

[(c)**]** (d) The commissioner shall submit biannual reports to the council, established pursuant to section 17b-28, on the department's compliance with the administrative processing requirements set forth in subsection (b) of this section.

Sec. 5. Section 17b-289 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) Sections 17b-289 to 17b-303, inclusive, and section 16 of public act 97-1 of the October 29 special session* shall be known as the "HUSKY and HUSKY Plus Act".

(b) Children, caretaker relatives and pregnant women receiving assistance under section 17b-261 or 17b-277 shall be participants in the HUSKY Plan, Part A and children receiving assistance under sections 17b-289 to 17b-303, inclusive, and section 16 of public act 97-1 of the October 29 special session* shall be participants in the HUSKY Plan, Part B. For purposes of marketing and outreach and enrollment of persons eligible for assistance, both parts shall be known as the HUSKY Plan.

Sec. 6. Section 17b-292 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) A child who resides in a household with a family income which exceeds one hundred eighty-five per cent of the federal poverty level and does not exceed **[**three**]** four hundred per cent of the federal poverty level may be eligible for subsidized benefits under the HUSKY Plan, Part B.

(b) A child who resides in a household with a family income over **[**three**]** four hundred per cent of the federal poverty level may be eligible for unsubsidized benefits under the HUSKY Plan, Part B.

(c) Whenever a court or family support magistrate orders a noncustodial parent to provide health insurance for a child, such parent may provide for coverage under the HUSKY Plan, Part B.

(d) To the extent allowed under federal law, the commissioner shall not pay for services or durable medical equipment under the HUSKY Plan, Part B if the enrollee has other insurance coverage for the services or such equipment.

(e) A newborn child who otherwise meets the eligibility criteria for the HUSKY Plan, Part B shall be eligible for benefits retroactive to his or her date of birth, provided an application is filed on behalf of the child **[**within**]** not later than thirty days **[**of**]** after such date. Any uninsured child born in a hospital in this state or in a border state hospital shall be enrolled on an expedited basis in the HUSKY Plan, Part B, provided (1) the parent or caretaker relative of such child resides in this state, and (2) the parent or caretaker relative of such child authorizes enrollment in the program. The commissioner shall pay any premium cost such family would otherwise incur for the first two months of coverage to the managed care organization selected by the parent or caretaker relative to provide coverage for such child.

(f) The commissioner shall implement presumptive eligibility for children applying for Medicaid. Such presumptive eligibility determinations shall be in accordance with applicable federal law and regulations. The commissioner shall adopt regulations, in accordance with chapter 54, to establish standards and procedures for the

designation of organizations as qualified entities to grant presumptive eligibility. Qualified entities shall ensure that, at the time a presumptive eligibility determination is made, a completed application for Medicaid is submitted to the department for a full eligibility determination. In establishing such standards and procedures, the commissioner shall ensure the representation of state-wide and local organizations that provide services to children of all ages in each region of the state.

(g) The commissioner shall enter into a contract with an entity to be a single point of entry servicer for applicants and enrollees under the HUSKY Plan, Part A and Part B. **[**The servicer**]** The commissioner, in consultation with the servicer, shall establish a centralized unit to be responsible for processing all applications for assistance under the HUSKY Plan, Part A and Part B. The department, through its contract with the servicer, shall ensure that a child who is determined to be eligible for benefits under the HUSKY Plan, Part A, or the HUSKY Plan, Part B has uninterrupted health insurance coverage for as long as the parent or guardian elects to enroll or re-enroll such child in the HUSKY Plan, Part A or Part B. The commissioner, in consultation with the servicer, and in accordance with the provisions of section 17b-297, as amended by this act, shall jointly market both Part A and Part B together as the HUSKY Plan **[**. Such servicer**]** and shall develop and implement public information and outreach activities with community programs. Such servicer shall electronically transmit data with respect to enrollment and disenrollment in the HUSKY Plan, Part A and Part B to the commissioner.

(h) Upon the expiration of any contractual provisions entered into pursuant to subsection (g) of this section, the commissioner shall develop a new contract for single point of entry services and managed care enrollment brokerage services. The commissioner may enter into one or more contractual arrangements for such services for a contract period not to exceed seven years. Such contracts shall include performance measures, including, but not limited to, specified time limits for the processing of applications, parameters setting forth the

requirements for a completed and reviewable application and the percentage of applications forwarded to the department in a complete and timely fashion. Such contracts shall also include a process for identifying and correcting noncompliance with established performance measures, including sanctions applicable for instances of continued noncompliance with performance measures.

(i) The single point of entry servicer shall send **[**an application**]** all applications and supporting documents to the commissioner for determination of eligibility. **[**of a child who resides in a household with a family income of one hundred eighty-five per cent or less of the federal poverty level.**]** The servicer shall enroll eligible beneficiaries in the applicant's choice of managed care plan. Upon enrollment in a managed care plan, an eligible HUSKY Plan Part A or Part B beneficiary shall remain enrolled in such managed care plan for twelve months from the date of such enrollment unless (1) an eligible beneficiary demonstrates good cause to the satisfaction of the commissioner of the need to enroll in a different managed care plan, or (2) the beneficiary no longer meets program eligibility requirements.

(j) Not **[**more than twelve**]** later than ten months after the determination of eligibility for benefits under the HUSKY Plan, Part A and Part B and annually thereafter, the commissioner or the servicer, as the case may be, shall determine if the child continues to be eligible for the plan. The commissioner or the servicer shall, within existing budgetary resources, mail or, upon request of a participant, electronically transmit an application form to each participant in the plan for the purposes of obtaining information to make a determination on continued eligibility beyond the twelve months of initial eligibility. To the extent permitted by federal law, in determining eligibility for benefits under the HUSKY Plan, Part A or Part B with respect to family income, the commissioner or the servicer shall rely upon information provided in such form by the participant unless the commissioner or the servicer has reason to believe that such information is inaccurate or incomplete. The Department of Social Services shall annually review a random sample of cases to confirm

that, based on the statistical sample, relying on such information is not resulting in ineligible clients receiving benefits under HUSKY Plan Part A or Part B. The determination of eligibility shall be coordinated with health plan open enrollment periods.

(k) The commissioner shall implement the HUSKY Plan, Part B while in the process of adopting necessary policies and procedures in regulation form in accordance with the provisions of section 17b-10.

(l) The commissioner shall adopt regulations, in accordance with chapter 54, to establish residency requirements and income eligibility for participation in the HUSKY Plan, Part B and procedures for a simplified mail-in application process. Notwithstanding the provisions of section 17b-257b, such regulations shall provide that any child adopted from another country by an individual who is a citizen of the United States and a resident of this state shall be eligible for benefits under the HUSKY Plan, Part B upon arrival in this state.

Sec. 7. Section 17b-295 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) The commissioner shall impose cost-sharing requirements, including the payment of a premium or copayment, in connection with services provided under the HUSKY Plan, Part B, to the extent permitted by federal law, and in accordance with the following limitations:

(1) **[**On and after July 1, 2005, the**]** The commissioner may increase the maximum annual aggregate cost-sharing requirements, provided such cost-sharing requirements shall not exceed five per cent of the family's gross annual income. The commissioner may impose a premium requirement on families whose income exceeds two hundred thirty-five per cent of the federal poverty level as a component of the family's cost-sharing responsibility, provided: (A) The family's annual combined premiums and copayments do not exceed the maximum annual aggregate cost-sharing requirement, **[**and**]** (B) premium requirements for a family with income that exceeds two hundred

thirty-five per cent of the federal poverty level but does not exceed three hundred per cent of the federal poverty level shall not exceed the sum of thirty dollars per month per child, with a maximum premium of fifty dollars per month per family, and (C) premium requirements for a family with income that exceeds three hundred per cent of the federal poverty level but does not exceed four hundred per cent of the federal poverty level who does not have any access to employer-sponsored health insurance coverage shall not exceed the sum of fifty dollars per child, with a maximum premium of seventy-five dollars per month. The commissioner shall not impose a premium requirement on families whose income exceeds one hundred eighty-five per cent of the federal poverty level but does not exceed two hundred thirty-five per cent of the federal poverty level; and

(2) The commissioner shall require each managed care plan to monitor copayments and premiums under the provisions of subdivision (1) of this subsection.

(b) (1) Except as provided in subdivision (2) of this subsection, the commissioner may impose limitations on the amount, duration and scope of benefits under the HUSKY Plan, Part B.

(2) The limitations adopted by the commissioner pursuant to subdivision (1) of this subsection shall not preclude coverage of any item of durable medical equipment or service that is medically necessary.

Sec. 8. Section 17b-297 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) The commissioner, in consultation with the Children's Health Council, the Medicaid Managed Care Council and the 2-1-1 Infoline **[**of Connecticut**]** program, shall develop mechanisms **[**for outreach for**]** to increase outreach and maximize enrollment of eligible children and adults in the HUSKY Plan, Part A **[**and**]** or Part B, including, but not limited to, development of mail-in applications and appropriate outreach materials through the Department of Revenue Services, the

Labor Department, the Department of Social Services, the Department of Public Health, the Department of Children and Families and the Office of Protection and Advocacy for Persons with Disabilities. Such mechanisms shall seek to maximize federal funds where appropriate for such outreach activities.

(b) The commissioner shall include in such outreach efforts information on the Medicaid program for the purpose of maximizing enrollment of eligible children and the use of federal funds.

(c) The commissioner shall, within available appropriations, contract with severe need schools and community-based organizations for purposes of public education, outreach and recruitment of eligible children, including the distribution of applications and information regarding enrollment in the HUSKY Plan, Part A and Part B. In awarding such contracts, the commissioner shall consider the marketing, outreach and recruitment efforts of organizations. For the purposes of this subsection, (1) "community-based organizations" shall include, but not be limited to, day care centers, schools, school-based health clinics, community-based diagnostic and treatment centers and hospitals, and (2) "severe need school" means a school in which forty per cent or more of the lunches served are served to students who are eligible for free or reduced price lunches.

(d) The commissioner, in consultation with the Latino and Puerto Rican Affairs Commission, the African-American Affairs Commission, representatives from minority community-based organizations and any other state and local organizations deemed appropriate by the commissioner, shall develop and implement outreach efforts that target medically underserved children and adults, particularly Latino and other minority children and adults, to increase enrollment of such children and adults in the HUSKY Plan, Part A or Part B. Such efforts shall include, but not be limited to, developing culturally appropriate outreach materials, advertising through Latino media outlets and other minority media outlets, and the public education, outreach and recruitment activities described in subsections (a) to (c), inclusive, of

this section.

[(d)**]** (e) All outreach materials shall be approved by the commissioner pursuant to Subtitle J of Public Law 105-33, as amended from time to time.

[(e)**]** (f) Not later than January 1, **[**1999**]** 2008, and annually thereafter, the commissioner shall submit a report to the Governor and the General Assembly on the implementation of and the results of the community-based outreach **[**program**]** programs specified in subsections (a) to **[**(c)**]** (d), inclusive, of this section.

Sec. 9. Subsection (a) of section 17b-297b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(a) To the extent permitted by federal law, the Commissioners of Social Services and Education shall jointly establish procedures for the sharing of information contained in applications for free and reduced price meals under the National School Lunch Program for the purpose of determining whether children participating in said program are eligible for coverage under the HUSKY Plan, Part A and Part B. The Commissioner of Social Services shall take all actions necessary to ensure that children identified as eligible for either the HUSKY Plan, Part A or Part B, are **[**able to enroll in said**]** enrolled in the appropriate plan.

Sec. 10. (NEW) (*Effective July 1, 2007*) (a) Notwithstanding the provisions of section 17b-299 of the general statutes, the Commissioner of Social Services shall establish a health insurance premium assistance program for individuals with dependent children who have income that exceeds three hundred per cent of the federal poverty level but does not exceed four hundred per cent of the federal poverty level and who have access to employer-sponsored health insurance. Individuals who elect to participate in such program shall be required to enroll themselves and their dependent children in employer-sponsored health insurance to the maximum extent of available coverage as a

condition of eligibility, provided the Department of Social Services determines that enrollment in the employer-sponsored coverage is more cost effective than enrolling the dependent children of such individual in the HUSKY Plan, Part B.

(b) Any individual who elects to participate in such program shall receive a health insurance premium assistance subsidy from the state in an amount equal to the portion of the premium payment that is attributable to the health insurance coverage for the dependent children. The employer of such individual shall provide verification of the cost of the health insurance premium payment that is attributable to the health insurance coverage for the dependent children to the Department of Social Services in a form and manner as prescribed by the department. The cost of the health insurance premium payment that is attributable to the health insurance coverage for the dependent children shall not be deducted from such individual's weekly income, but instead such cost shall be transmitted directly to and paid for by the Department of Social Services. In addition, the Department of Social Services shall provide to the dependents of any individual who receives health insurance premium assistance in accordance with the provisions of this section, HUSKY Plan, Part B coverage for medical assistance or services not covered by the available employment sponsored health insurance.

(c) The Commissioner of Social Services, pursuant to section 17b-10 of the general statutes, may implement policies and procedures necessary to administer the provisions of this section while in the process of adopting such policies and procedures as regulation, provided the commissioner prints notice of the intent to adopt the regulation in the Connecticut Law Journal not later than twenty days after the date of implementation. Policies and procedures implemented pursuant to this section shall be valid until the time final regulations are adopted.

Sec. 11. Section 19a-88 of the general statutes is amended by adding subsection (g) as follows (*Effective from passage*):

(NEW) (g) On or before July 1, 2008, the Department of Public Health shall establish and implement a secure on-line license renewal system for persons holding a license to practice medicine or surgery under chapter 370, dentistry under chapter 379 or nursing under chapter 378. The department shall allow any such person who renews his or her license using the on-line license renewal system to pay his or her professional service fees on-line by means of a credit card or electronic transfer of funds from a bank or credit union account and may charge such person a service fee not to exceed five dollars for any such on-line payment made by credit card or electronic funds transfer.

Sec. 12. (NEW) (*Effective July 1, 2007*) On or before January 1, 2008, the Commissioner of Social Services, shall seek a waiver under federal law under the Health Insurance Flexibility and Accountability demonstration proposal to provide health insurance coverage to pregnant women, who do not otherwise have creditable coverage, as defined in 42 USC 300gg(c), and with incomes above one hundred eighty-five per cent of the federal poverty level but not in excess of two hundred fifty per cent of the federal poverty level. The waiver submitted by the commissioner shall specify that funding for such health insurance coverage shall be provided through a reallocation of unspent state children's health insurance plan funds.

Sec. 13. (NEW) (*Effective July 1, 2007*) (a) The Commissioner of Social Services, in consultation with the Commissioner of Public Health, shall develop and implement a plan for a system of preventive health services for children under the HUSKY Plan, Part A and Part B. The goal of the system shall be to improve health outcomes for all children enrolled in the HUSKY Plan and to reduce racial and ethnic health disparities among children. Such system shall ensure that services under the federal Early and Periodic Screening, Diagnosis and Treatment program are provided to children enrolled in the HUSKY Plan, Part A.

(b) The plan shall:

(1) Establish a coordinated system for preventive health services for HUSKY Plan, Part A and Part B beneficiaries including, but not limited to, services under the federal Early and Periodic Screening, Diagnosis and Treatment program, vision care, oral health care, care coordination, chronic disease management and periodicity schedules based on standards specified by the American Academy of Pediatrics;

(2) Require the Department of Social Services to track electronically the utilization of services in the system of preventive health services by HUSKY Plan, Part A and Part B beneficiaries to ensure that such beneficiaries receive all the services available under the system and to track the health outcomes of children; and

(3) Include payment methodologies to create financial incentives and rewards for health care providers who participate and provide services in the system, such as case management fees, pay for performance, and payment for technical support and data entry associated with patient registries.

(c) The Commissioner of Social Services shall develop the plan for a system of preventive health services not later than January 1, 2008, and implement the plan not later than July 1, 2008.

(d) Not later than July 1, 2009, the Commissioner of Social Services shall report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to human services, insurance and public health on the implementation of the plan for a system of preventive health services. The report shall include information on health outcomes, quality of care and methodologies utilized in the plan to improve the quality of care and health outcomes for children.

Sec. 14. (NEW) (*Effective July 1, 2007*) (a) The Commissioner of Social Services, in collaboration with the Commissioners of Public Health and Children and Families, shall establish a child health quality improvement program for the purpose of promoting the

implementation of evidence-based strategies by providers participating in the HUSKY Plan, Part A and Part B to improve the delivery of and access to children's health services. Such strategies shall focus on physical, dental and mental health services and shall include, but need not be limited to: (1) Methods for early identification of children with special health care needs; (2) integration of care coordination and care planning into children's health services; (3) implementation of standardized data collection to measure performance improvement; and (4) implementation of family-centered services in patient care, including, but not limited to, the development of parent-provider partnerships. The Commissioner of Social Services shall seek the participation of public and private entities that are dedicated to improving the delivery of health services, including medical, dental and mental health providers, academic professionals with experience in health services research and performance measurement and improvement, and any other entity deemed appropriate by the Commissioner of Social Services, to promote such strategies. The commissioner shall ensure that such strategies reflect new developments and best practices in the field of children's health services. As used in this section, "evidence-based strategies" means policies, procedures and tools that are informed by research and supported by empirical evidence, including, but not limited to, research developed by organizations such as the American Academy of Pediatrics, the American Academy of Family Physicians, the National Association of Pediatric Nurse Practitioners and the Institute of Medicine.

(b) Not later than July 1, 2008, and annually thereafter, the Commissioner of Social Services shall report, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to human services, public health and appropriations, and to the Medicaid Managed Care Council on (1) the implementation of any strategies developed pursuant to subsection (a) of this section, and (2) the efficacy of such strategies in improving the delivery of and access to

health services for children enrolled in the HUSKY Plan.

Sec. 15. Section 38a-482 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

No individual health insurance policy shall be delivered or issued for delivery to any person in this state unless: (1) The entire money and other considerations therefor are expressed therein; (2) the time at which the insurance takes effect and terminates is expressed therein; (3) such policy purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family, who shall be deemed the policyholder, any two or more eligible members of such family, including husband, wife, dependent children or any children **[**under a specified age, which shall not exceed eighteen years**]** as specified in section 38a-497, as amended by this act, and any other person dependent upon the policyholder; (4) the style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lowercase unspaced alphabet length not less than one hundred and twenty-point, the word "text" as herein used including all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions; (5) the exceptions and reductions of indemnity are set forth in the policy and, except as provided in section 38a-483, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS" or "EXCEPTIONS AND REDUCTIONS", provided, if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies; (6) each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and (7) such policy contains no provision purporting

to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner.

Sec. 16. Section 38a-497 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

Every individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, amended or renewed in this state on or after October 1, **[**1982**]** 2007, shall provide that coverage of a child shall terminate no earlier than the policy anniversary date on or after whichever of the following occurs first, the date on which the child marries, ceases to be a **[**dependent of the policyholder,**]** resident of the state or attains the age of **[**nineteen if the child is not a full-time student at an accredited institution, or attains the age of twenty-three if the child is a full-time student at an accredited institution**]** twenty-six.

Sec. 17. Section 38a-554 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

A group comprehensive health care plan shall contain the minimum standard benefits prescribed in section 38a-553 and shall also conform in substance to the requirements of this section.

(a) The plan shall be one under which the individuals eligible to be covered include: (1) Each eligible employee; (2) the spouse of each eligible employee, who shall be considered a dependent for the purposes of this section; and (3) **[**dependent**]** unmarried children residing in the state, who are under **[**the age of nineteen or are full-time students under the age of twenty-three at an accredited institution of higher learning**]** twenty-six years of age.

(b) The plan shall provide the option to continue coverage under each of the following circumstances until the individual is eligible for

other group insurance, except as provided in subdivisions (3) and (4) of this subsection: (1) Notwithstanding any provision of this section, upon layoff, reduction of hours, leave of absence, or termination of employment, other than as a result of death of the employee or as a result of such employee's "gross misconduct" as that term is used in 29 USC 1163(2), continuation of coverage for such employee and such employee's covered dependents for the periods set forth for such event under federal extension requirements established by the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time, (COBRA), except that if such reduction of hours, leave of absence or termination of employment results from an employee's eligibility to receive Social Security income, continuation of coverage for such employee and such employee's covered dependents until midnight of the day preceding such person's eligibility for benefits under Title XVIII of the Social Security Act; (2) upon the death of the employee, continuation of coverage for the covered dependents of such employee for the periods set forth for such event under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time, (COBRA); (3) regardless of the employee's or dependent's eligibility for other group insurance, during an employee's absence due to illness or injury, continuation of coverage for such employee and such employee's covered dependents during continuance of such illness or injury or for up to twelve months from the beginning of such absence; (4) regardless of an individual's eligibility for other group insurance, upon termination of the group plan, coverage for covered individuals who were totally disabled on the date of termination shall be continued without premium payment during the continuance of such disability for a period of twelve calendar months following the calendar month in which the plan was terminated, provided claim is submitted for coverage within one year of the termination of the plan; (5) the coverage of any covered individual shall terminate: (A) As to a child, the plan shall provide the option for said child to continue coverage for the longer of the following periods: (i) At the end of the month following the month in

which the child marries, ceases to **[**be dependent on the employee**]** reside in the state or attains the age of **[**nineteen, whichever occurs first, except that if the child is a full-time student at an accredited institution, the coverage may be continued while the child remains unmarried and a full-time student, but not beyond the month following the month in which the child attains the age of twenty-three**]** twenty-six. If on the date specified for termination of coverage on a **[**dependent**]** child, the child is unmarried and incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent upon the employee for support and maintenance, the coverage on such child shall continue while the plan remains in force and the child remains in such condition, provided proof of such handicap is received by the carrier within thirty-one days of the date on which the child's coverage would have terminated in the absence of such incapacity. The carrier may require subsequent proof of the child's continued incapacity and dependency but not more often than once a year thereafter, or (ii) for the periods set forth for such child under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time, (COBRA); (B) as to the employee's spouse, at the end of the month following the month in which a divorce, court-ordered annulment or legal separation is obtained, whichever is earlier, except that the plan shall provide the option for said spouse to continue coverage for the periods set forth for such events under federal extension requirements established by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended from time to time, (COBRA); and (C) as to the employee or dependent who is sixty-five years of age or older, as of midnight of the day preceding such person's eligibility for benefits under Title XVIII of the federal Social Security Act; (6) as to any other event listed as a "qualifying event" in 29 USC 1163, as amended from time to time, continuation of coverage for such periods set forth for such event in 29 USC 1162, as amended from time to time, provided such plan may require the individual whose coverage is to be continued to pay up to the percentage of the applicable premium as specified for such event in

29 USC 1162, as amended from time to time. Any continuation of coverage required by this section except subdivision (4) or (6) of this subsection may be subject to the requirement, on the part of the individual whose coverage is to be continued, that such individual contribute that portion of the premium the individual would have been required to contribute had the employee remained an active covered employee, except that the individual may be required to pay up to one hundred two per cent of the entire premium at the group rate if coverage is continued in accordance with subdivision (1), (2) or (5) of this subsection. The employer shall not be legally obligated by sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, to pay such premium if not paid timely by the employee.

(c) The commissioner shall adopt regulations, in accordance with chapter 54, concerning coordination of benefits between the plan and other health insurance plans.

(d) The plan shall make available to Connecticut residents, in addition to any other conversion privilege available, a conversion privilege under which coverage shall be available immediately upon termination of coverage under the group plan. The terms and benefits offered under the conversion benefits shall be at least equal to the terms and benefits of an individual comprehensive health care plan.

Sec. 18. Subdivision (19) of section 38a-564 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(19) "Low-income eligible employee" means an eligible employee of a small employer whose annualized wages from such small employer determined as of the effective date of the special health care plan or as of any anniversary of such effective date as certified to the insurer or insurance arrangement or the Health Reinsurance Association, as the case may be, by such small employer is less than **[**two**]** three hundred per cent of the federal poverty level applicable to such person.

Sec. 19. Subdivision (24) of section 38a-564 of the general statutes is

repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(24) "Low-income individual" means an individual whose adjusted gross income (AGI) for the individual and spouse, from the most recent federal tax return filed prior to the date of application for the individual special health care plan or prior to any anniversary of the effective date of the plan, as certified by such individual, is less than **[**two**]** three hundred per cent of the applicable federal poverty level.

Sec. 20. Subsection (b) of section 38a-565 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

(b) (1) Within ninety days after approval by the commissioner of special health care plans submitted by the board, every small employer carrier shall, as a condition of transacting such business in this state, offer small employers a special health care plan, provided no small employer carrier may be required to offer a special health care plan to a small employer with ten or fewer eligible employees, the majority of whom are low-income eligible employees. Such employers may purchase a special health care plan from the Health Reinsurance Association pursuant to section 38a-570. Small employer carriers that do not offer special health care plans to such employers shall refer those employers to the Health Reinsurance Association. Except as provided in subdivision (2) of this subsection, every small employer which elects to be covered under a special health care plan and agrees to make the required premium payments and to satisfy the other provisions of the plan shall be issued such a plan by the small employer carrier or the Health Reinsurance Association, as the case may be.

(2) No small employer may be eligible to purchase a special health care plan unless such employer had maintained no health insurance coverage for its employees at any time during the one-year period ending on the date of application for such policy. No small employer

may purchase a special health care plan for more than three years.

[(3) No special health care plan may be sold with an initial effective date of January 1, 1995, or later.**]**

[(4)**]** (3) In addition to any other requirements related to the establishment of premiums for special health care plans issued by small employer carriers to small employers, (A) the anticipated loss ratio shall not be less than seventy-five per cent of the premium, and (B) small employer carriers shall file annually by the end of March of each year information with the Insurance Department with respect to such plans for the prior calendar year including the number of plans issued, the anticipated loss ratio, the premiums earned, the paid and estimated outstanding claims, expenses charged, and such other information as the commissioner deems necessary to assure compliance with subparagraph (A) of this subdivision.

[(5)**]** (4) A health care center shall not be required to offer coverage or accept applications pursuant to subdivision (1) of this subsection in the case of any of the following: (A) To a group, where the group is not physically located in the health care center's approved service area; (B) to an employee, where the employee does not work or reside within the health care center's approved service area; (C) within an area where the health care center reasonably anticipates, and demonstrates to the satisfaction of the commissioner, that it will not have the capacity within that area in its network of providers to deliver services adequately to the members of such groups because of its obligations to existing group contract holders and enrollees; (D) where the commissioner finds that acceptance of an application or applications would place the health care center in an impaired financial condition; or (E) to groups of fewer than three eligible employees, where the health care center does not utilize preexisting condition provisions in the plans it issues to any small employers. A health care center that refuses to offer coverage pursuant to subparagraph (C) of this subdivision may not, for ninety days after such refusal, offer coverage in the applicable area to new cases of employer groups with more than

twenty-five eligible employees.

[(6)**]** (5) A small employer carrier shall not be required to offer coverage or accept applications pursuant to subdivision (1) of this subsection subject to the following conditions: (A) The small employer carrier ceases to market health insurance or health benefit plans to small employers and ceases to enroll small employers under existing health insurance or health benefit plans; (B) the small employer carrier notifies the commissioner of its decision to cease marketing to small employers and to cease enrolling small employers, as provided in subparagraph (A) of this subdivision; and (C) the small employer carrier is prohibited from reentering the small employer market for a period of five years from the date of the notice required under subparagraph (B) of this subdivision.

Sec. 21. Section 38a-570 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2007*):

Notwithstanding the provisions of sections 38a-505, 38a-546 and 38a-551 to 38a-559, inclusive, the Health Reinsurance Association may issue special health care plans to small employers with ten or fewer eligible employees, the majority of whom are low-income eligible employees. The following provisions shall apply to such special health care plans:

(1) Premium rates shall be promulgated by the board of directors of the Health Reinsurance Association based on recommendations of its actuarial committee. In developing recommendations for premium rates, the actuarial committee shall consider, in addition to other pertinent matters, the premiums that are or would be charged for the same or similar insurance by other insurers. Except as otherwise provided in sections 38a-564 to 38a-572, inclusive, in establishing premium rates the board of directors of the Health Reinsurance Association may consider any relevant factors impacting premium, claims and expenses, including characteristics of small employers and insureds, that may be considered by any insurer in establishing health

insurance premium rates. The premium rates established shall be subject to the provisions of section 38a-567. The anticipated loss ratio shall not be less than eighty per cent of the premium. In establishing premium rates **[**it shall be the goal of**]** the board of directors of the Health Reinsurance Association **[**to**]** shall administer special health care plans issued to small employers without gain or loss; and

(2) The Health Reinsurance Association may reinsure coverage of special health care plans with the pool.

Sec. 22. Section 38a-1041 of the general statutes is amended by adding subsection (f) as follows (*Effective October 1, 2007*):

(NEW) (f) On or before October 1, 2008, the Office of the Healthcare Advocate shall, within available appropriations, establish and maintain a healthcare consumer information web site on the Internet for use by the public in obtaining healthcare information, including but not limited to: (1) The availability of wellness programs in various regions of Connecticut, such as disease prevention and health promotion programs; (2) quality and experience data from hospitals licensed in this state; and (3) a link to the consumer report card developed and distributed by the Insurance Commissioner pursuant to section 38a-478*l*.

Sec. 23. (NEW) (*Effective October 1, 2007*) Any employer that provides health insurance benefits to its employees for which any portion of the premiums are deducted from the employees' pay shall offer such employees the opportunity to have such portion excluded from their gross income for state or federal income tax purposes, except as required under Section 125 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as from time to time amended.

Sec. 24. (NEW) (*Effective July 1, 2007*) eHealth Connecticut shall be designated the lead health information exchange organization for the state of Connecticut for the period commencing July 1, 2007, and ending July 1, 2012. The Commissioner of Public Health shall contract

with such organization to develop a state-wide health information technology plan, which includes development of standards, protocols and pilot programs for health information exchange.

Sec. 25. (NEW) (*Effective July 1, 2007*) (a) As used in this section:

(1) "Electronic health information system" means an information processing system, involving both computer hardware and software that deals with the storage, retrieval, sharing and use of health care information, data and knowledge for communication and decision making, and includes: (A) An electronic health record that provides access in real-time to a patient's complete medical record; (B) a personal health record through which an individual, and anyone authorized by such individual, can maintain and manage such individual's health information; (C) computerized order entry technology that permits a health care provider to order diagnostic and treatment services, including prescription drugs electronically; (D) electronic alerts and reminders to health care providers to improve compliance with best practices, promote regular screenings and other preventive practices, and facilitate diagnoses and treatments; (E) error notification procedures that generate a warning if an order is entered that is likely to lead to a significant adverse outcome for a patient; and (F) tools to allow for the collection, analysis and reporting of data on adverse events, near misses, the quality and efficiency of care, patient satisfaction and other healthcare-related performance measures.

(2) "Interoperability" means the ability of two or more systems or components to exchange information and to use the information that has been exchanged and includes: (A) The capacity to physically connect to a network for the purpose of exchanging data with other users; (B) the ability of a connected user to demonstrate appropriate permissions to participate in the instant transaction over the network; and (C) the capacity of a connected user with such permissions to access, transmit, receive and exchange usable information with other users.

(3) "Standard electronic format" means a format using open electronic standards that: (A) Enable health information technology to be used for the collection of clinically specific data; (B) promote the interoperability of health care information across health care settings, including reporting to local, state and federal agencies; and (C) facilitate clinical decision support.

(b) On or before July 1, 2008, the Department of Public Health, in consultation with the Departments of Social Services and Information Technology, and any other entity deemed appropriate by the Commissioner of Public Health, shall develop electronic data standards to facilitate the development of a state-wide, integrated electronic health information system for use by health care providers and institutions that are funded by the state. The electronic data standards shall (1) include provisions relating to security, privacy, data content, structures and format, vocabulary and transmission protocols, (2) be compatible with any national data standards in order to allow for interstate interoperability, (3) permit the collection of health information in a standard electronic format, and (4) be compatible with the requirements for an electronic health information system.

(c) The Department of Public Health may contract for the development of the electronic data standards through a request for proposals process.

(d) Not later than October 1, 2008, the department shall report, in accordance with section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health, human services, government administration and appropriations on the electronic data standards developed pursuant to subsection (b) of this section.

Sec. 26. (NEW) (*Effective October 1, 2007*) (a) There is established at The University of Connecticut Health Center a Connecticut Health Information Network, which shall securely integrate state health and social services data, consistent with state and federal privacy laws,

within and across The University of Connecticut Health Center, the Office of Health Care Access and the Departments of Public Health, Mental Retardation and Children and Families. Data from other state agencies may be integrated into the network as funding permits and as permissible under federal law.

(b) The Center for Public Health and Health Policy at The University of Connecticut Health Center, in collaboration with the Departments of Information Technology, Public Health, Mental Retardation, Children and Families and the Office of Health Care Access shall develop, implement and administer the Connecticut Health Information Network.

(c) The Connecticut Health Information Network shall develop a framework for creating the Connecticut Community Health Data and Information Portal, which shall be capable of providing (1) access to public use datasets containing health and social services information concerning Connecticut residents, maintained by state agencies and other nongovernmental entities, and (2) a platform to query the network to obtain aggregate data on key health indicators within the state. The Connecticut Community Health Data and Information Portal shall be designed to:

(A) Provide accurate, timely and accessible health data to public and private sector leaders and policy makers at the state and local level, and inform citizens to improve community and individual health;

(B) Adhere to strict confidentiality and privacy standards;

(C) Support efforts to reduce health disparities; and

(D) Identify the best available data sources and coordinate the compilation of extant health-related data and statistics.

Sec. 27. (NEW) (*Effective October 1, 2007*) (a) There is established a Connecticut Health Information Network Governing Board to oversee the Connecticut Health Information Network established under section

26 of this act.

(b) The governing board shall consist of the following members:

(1) One appointed by the Governor, who shall serve as the chairperson;

(2) One appointed by the speaker of the House of Representatives;

(3) One appointed by the president pro tempore of the Senate;

(4) One appointed by the majority leader of the House of Representatives who shall represent consumers;

(5) One appointed by the minority leader of the House of Representatives who shall represent data users;

(6) One appointed by the majority leader of the Senate, who shall be a local director of health;

(7) One appointed by the minority leader of the Senate, who shall be a privacy advocate;

(8) One appointed by The University of Connecticut Health Center; and

(9) The Commissioners of Public Health, Mental Retardation, Children and Families and Health Care Access and the Chief Information Officer of the Department of Information Technology shall be ex-officio, nonvoting members.

(c) All initial appointments to the board shall be made not later than November 30, 2007. The term of each appointed governing board member shall be four years or until a successor is chosen, whichever is later. Any vacancy shall be filled by the appointing authority.

(d) The chairperson shall schedule the first meeting of the board, which shall be held not later than December 31, 2007.

(e) The governing board shall meet at least once during each calendar quarter and at such other times as the chairperson deems necessary. A majority of the members shall constitute a quorum for the transaction of business.

(f) The duties and responsibilities of the governing board shall be to: (1) Establish and implement policies, procedures and protocols governing access and dissemination of data through the Connecticut Health Information Network; (2) establish such permanent and ad hoc committees as it deems necessary to facilitate the implementation, operation and maintenance of the network; (3) recommend any legislation necessary for implementation, operation and maintenance of the network; (4) perform all necessary functions to facilitate the coordination and integration of the network; and (5) report annually to the Governor and the General Assembly on the status and operations of the Connecticut Health Information Network, including any recommendations for funding.

Sec. 28. (NEW) (*Effective October 1, 2007*) (a) Notwithstanding any provision of chapter 14, 319, 319b, 319o, 319s, 319t, 319v or 368a of the general statutes, or any regulation adopted pursuant to said chapters, and subject to federal restrictions on disclosure or redisclosure of such information, the state agencies that participate in the Connecticut Health Information Network may disclose personally identifiable information held in agency databases to the administrator of the Connecticut Health Information Network and its subcontractors for the purposes of (1) network development and verification, and (2) data integration and aggregation to enable response to network queries approved by the commissioner of the department with primary responsibility for collecting or maintaining such information. Such approval shall not be denied unless disclosure of such personally identifiable information to the Connecticut Health Information Network would constitute a violation of federal law, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) (HIPAA), as amended from time to time, and the Family Educational Rights and Privacy Act of 1974, 20 USC 1232g,

(FERPA), as amended from time to time, and any regulations promulgated thereunder at 34 CFR Part 99.

(b) The Connecticut Health Information Network may use such personally identifiable information for the purposes of (1) matching data across or within participating agency databases, including selected health databases at The University of Connecticut Health Center, and (2) providing data without personally identifiable information in response to queries approved by the Connecticut Health Information Network Governing Board. The network may not redisclose such personally identifiable information, except when and as permitted by written agreements with state agencies or other network contributors that expressly authorize redisclosure of personally identifiable information, subject to all applicable state and federal laws. Neither the network nor any recipient of data from the network may redisclose such data in a manner that would disclose personally identifiable information or the identification of any individual to whom such data pertains.

Sec. 29. (*Effective from passage*) Not later than January 1, 2008, the Department of Social Services shall inventory and report, in accordance with the provisions of section 11-4a of the general statutes, on all disease management initiatives implemented as of the effective date of this section under the HUSKY Plan, Part A, the HUSKY Plan, Part B, the state-administered general assistance program and the state Medicaid plan to the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services. Such report shall include a summary of each initiative, the total amount of money spent on each initiative, from inception, and the total number of persons served by each initiative.

Sec. 30. (NEW) (*Effective from passage*) (a) There is established a HealthFirst Connecticut Authority composed of the following members: Two appointed by the speaker of the House of Representatives, one of whom is a health care provider and one of whom represents businesses with fifty or more employees; two

appointed by the president pro tempore of the Senate, one of whom has experience in community-based health care and one of whom represents businesses with fewer than fifty employees; one appointed by the majority leader of the House of Representatives who represents consumers; one appointed by the majority leader of the Senate who represents the interests of labor; one appointed by the minority leader of the House of Representatives who represents health insurance companies; one appointed by the minority leader of the Senate who represents hospitals; the Commissioners of Public Health and Social Services or their designees; the chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health or their designees; and two appointed by the Governor, one of whom advocates for health care quality or patient safety and one with experience in information technology.

(b) All appointments to the HealthFirst Connecticut Authority shall be made not later than thirty days after the effective date of this section and any vacancy shall be filled by the appointing authority not later than thirty days after the vacancy. If an appointing authority fails to make an appointment within any such thirty-day period, the chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall make such appointment.

(c) The speaker of the House of Representatives and the president pro tempore of the Senate shall each select a chairperson of the HealthFirst Connecticut Authority from among the members of the authority. Such chairpersons shall schedule the first meeting of the HealthFirst Connecticut Authority, which shall be held not later than sixty days after the effective date of this section.

(d) All members appointed to the authority shall be familiar with the criteria of the Institute of Medicine of the National Academies and shall be committed to making recommendations about health care reform for the state of Connecticut that are consistent with said criteria.

(e) The HealthFirst Connecticut Authority shall:

(1) Examine and evaluate policy alternatives for providing quality, affordable and sustainable health care for all individuals residing in this state, including, but not limited to, a state-wide single payer health care system and employer-sponsored health plans.

(2) Make recommendations for mechanisms to contain the cost and improve the quality of health care in this state, including, but not limited to: Health information technology; disease management and other initiatives to coordinate and improve the quality of care for people with chronic diseases; monitoring and reporting about the costs, quality and utilization of care, including assessment of consumer and provider satisfaction; and measures to encourage or require the provision of health care coverage to certain groups through participation in an insurance pool.

(3) Make recommendations regarding the financing of quality, affordable health care coverage for individuals residing in this state, including the maximization of federal funds to provide subsidies for health care, contributions from employers, employees and individuals and methods for financing the state's share of the cost of such coverage.

(4) Not later than December 1, 2008, report on its findings and recommendations with respect to such policy alternatives to the joint standing committees of the General Assembly having cognizance of matters relating to public health, social services and insurance, in accordance with the provisions of section 11-4a of the general statutes. Such report shall include recommended strategies for increasing access to health care for all of Connecticut's residents.

(f) The HealthFirst Connecticut Authority may apply for grants or financial assistance from any person, group of persons or corporation or from any agency of the state or of the United States.

Sec. 31. (NEW) (*Effective from passage*) (a) There is established a State-

wide Primary Care Access Authority. The authority shall consist of the Commissioners of Public Health and Social Services, the Comptroller, the chairpersons of the HealthFirst Connecticut Authority established under section 30 of this act and the following members: One each appointed by the Connecticut Primary Care Association, the Connecticut State Medical Society, the Connecticut Chapter of the American Academy of Pediatrics, the Connecticut Nurses Association, the Connecticut Association of School Based Health Centers and the Weitzman Center for Innovation In Community Health and Primary Care. Members shall serve for a term of four years commencing on August 1, 2007. All initial appointments to the committee shall be made by July 15, 2007. Any vacancy shall be filled by the appointing authority.

(b) The chairpersons of the HealthFirst Connecticut Authority established under section 30 of this act shall serve as cochairpersons of the State-wide Primary Care Access Authority. Members shall serve without compensation but shall, within available appropriations, be reimbursed for expenses necessarily incurred in the performance of their duties.

(c) The chairpersons shall convene the first meeting of the State-wide Primary Care Access Authority not later than October 1, 2007. Any member who fails to attend three consecutive meetings or who fails to attend fifty per cent of all meetings held during any calendar year shall be deemed to have resigned from the committee.

(d) All members appointed to the authority shall be familiar with the criteria of the Institute of Medicine of the National Academies and shall be committed to making recommendations about health care reform for the state of Connecticut that are consistent with said criteria.

(e) The State-wide Primary Care Access Authority shall:

(1) Determine what constitutes primary care services for purposes of subdivisions (2) to (4), inclusive, of this section;

(2) Inventory the state's existing primary care infrastructure, including, but not limited to, (A) the number of primary care providers practicing in the state, (B) the total amount of money expended on public and private primary care services during the last fiscal year, (C) the number of public and private buildings or offices used primarily for the rendering of primary care services, including, but not limited to, hospitals, mental health facilities, dental offices, school-based health clinics, community-based health centers and academic health centers. For the purposes of this subdivision, "primary care provider" means any physician, dentist, nurse, provider of services for the mentally ill or persons with mental retardation, or other person involved in providing primary medical, nursing, counseling, or other health care, substance abuse or mental health service, including such services associated with, or under contract to, a health maintenance organization or medical services plan.

(3) Not later than December 31, 2008, develop a universal system for providing primary care services, including prescription drugs, to all residents of the state that maximizes federal financial participation in Medicaid and Medicare. The committee shall (A) estimate the cost of fully implementing such universal system, (B) identify any additional infrastructure or personnel that would be necessary in order to fully implement such universal system, (C) determine the state's role and the role of third party entities in administering such universal system, (D) identify funding sources for such universal system, and (E) determine the role of private health insurance in such universal system.

(4) Develop a plan for implementing by July 1, 2010, the universal primary care system developed pursuant to subdivision (3) of this section. Such plan shall (A) include a timetable for implementation of the universal primary care system, (B) establish benchmarks to assess the state's progress in implementing the system, and (C) establish mechanisms for assessing the effectiveness of the primary care system, once implemented.

(f) The State-wide Primary Care Access Authority may (1) retain and employ consultants or assistants on a contract or other basis for rendering professional, legal, financial, technical or other assistance or advice as may be required to carry out its duties or responsibilities, and (2) apply for grants or financial assistance from any person, group of persons or corporation or from any agency of the state or of the United States.

(g) On or before February 1, 2008, and annually thereafter on or before January first, the State-wide Primary Care Access Authority shall report to the joint standing committees of the General Assembly having cognizance of matters relating to public health, insurance and human services, in accordance with the provisions of section 11-4a of the general statutes, concerning its progress in developing the universal primary care services system and the implementation plan for such system.

Sec. 32. (NEW) (*Effective from passage*) The committee established under section 51 of public act 06-195 shall meet at least once every calendar quarter and report annually to the joint standing committees of the General Assembly having cognizance of matters relating to public health and education, in accordance with the provisions of section 11-4a of the general statutes, on recommended statutory and regulatory changes to improve health care through access to school-based health clinics.

Sec. 33. (NEW) (*Effective July 1, 2007*) Any school-based health clinic constructed on or after October 1, 2007, that is located in or attached to a school building shall be constructed with an entrance that is separate from the entrance to the school building.

Sec. 34. (NEW) (*Effective July 1, 2007*) For the fiscal year ending June 30, 2008, and annually thereafter, the Department of Social Services shall, within existing budgetary resources, increase the rates paid to Medicaid providers and hospitals that provide services to Medicaid recipients.

Sec. 35. (*Effective July 1, 2007*) The sum of one hundred fifty thousand dollars is appropriated to the Department of Social Services, from the General Fund, for the fiscal year ending June 30, 2008, for the purposes of section 14 of this act.

Sec. 36. (*Effective July 1, 2007*) The sum of two hundred fifty thousand dollars is appropriated to the Department of Public Health, from the General Fund, for the fiscal year ending June 30, 2008, for the purposes of section 25 of this act.

Sec. 37. (*Effective July 1, 2007*) The sum of one million dollars is appropriated to The University of Connecticut Health Center, from the General Fund, for the fiscal year ending June 30, 2008, for the purpose of establishing and operating the Connecticut Health Information Network established under section 26 of this act.

Sec. 38. (*Effective July 1, 2008*) The sum of one million dollars is appropriated to The University of Connecticut Health Center, from the General Fund, for the fiscal year ending June 30, 2009, for the purpose of operating the Connecticut Health Information Network established under section 26 of this act.

Sec. 39. (*Effective July 1, 2008*) The sum of five hundred thousand dollars is appropriated to the Department of Public Health, from the General Fund, for the fiscal year ending June 30, 2009, for the HealthFirst Authority established pursuant to section 30 of this act.

Sec. 40. (*Effective July 1, 2008*) The sum of five hundred thousand dollars is appropriated to the Department of Public Health, from the General Fund, for the fiscal year ending June 30, 2009, for the State-wide Primary Care Access Authority established pursuant to section 31 of this act.

Sec. 41. (*Effective July 1, 2007*) The sum of two million five hundred thousand dollars is appropriated to the Department of Public Health, from the General Fund, for the fiscal year ending June 30, 2008, for the expansion and operation of school-based health clinics for priority

school districts pursuant to section 10-266p of the general statutes and areas designated by the federal Health Resources and Services Administration as health professional shortage areas, medically underserved areas or areas with a medically underserved population.

Sec. 42. (*Effective July 1, 2007*) The sum of five hundred thousand dollars is appropriated to the Department of Public Health, from the General Fund, for the fiscal year ending June 30, 2008, for grants to community-based health centers to provide transportation assistance to patients for medical appointments. Priority shall be given to federally-qualified health centers located in areas of the state with limited public transportation options.

Sec. 43. (*Effective July 1, 2007*) The sum of two million dollars is appropriated to the Department of Public Health, from the General Fund, for the fiscal year ending June 30, 2008, for grants to community-based health centers for infrastructure improvements, including, but not limited to, health information technology."

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2007*	17b-28e
Sec. 2	*July 1, 2007*	17b-192
Sec. 3	*July 1, 2007*	17b-261
Sec. 4	*July 1, 2007*	17b-277
Sec. 5	*July 1, 2007*	17b-289
Sec. 6	*July 1, 2007*	17b-292
Sec. 7	*July 1, 2007*	17b-295
Sec. 8	*July 1, 2007*	17b-297
Sec. 9	*July 1, 2007*	17b-297b(a)
Sec. 10	*July 1, 2007*	New section
Sec. 11	*from passage*	19a-88
Sec. 12	*July 1, 2007*	New section
Sec. 13	*July 1, 2007*	New section
Sec. 14	*July 1, 2007*	New section
Sec. 15	*July 1, 2007*	38a-482
Sec. 16	*July 1, 2007*	38a-497
Sec. 17	*July 1, 2007*	38a-554

Sec. 18	*July 1, 2007*	38a-564(19)
Sec. 19	*July 1, 2007*	38a-564(24)
Sec. 20	*July 1, 2007*	38a-565(b)
Sec. 21	*July 1, 2007*	38a-570
Sec. 22	*October 1, 2007*	38a-1041
Sec. 23	*October 1, 2007*	New section
Sec. 24	*July 1, 2007*	New section
Sec. 25	*July 1, 2007*	New section
Sec. 26	*October 1, 2007*	New section
Sec. 27	*October 1, 2007*	New section
Sec. 28	*October 1, 2007*	New section
Sec. 29	*from passage*	New section
Sec. 30	*from passage*	New section
Sec. 31	*from passage*	New section
Sec. 32	*from passage*	New section
Sec. 33	*July 1, 2007*	New section
Sec. 34	*July 1, 2007*	New section
Sec. 35	*July 1, 2007*	New section
Sec. 36	*July 1, 2007*	New section
Sec. 37	*July 1, 2007*	New section
Sec. 38	*July 1, 2008*	New section
Sec. 39	*July 1, 2008*	New section
Sec. 40	*July 1, 2008*	New section
Sec. 41	*July 1, 2007*	New section
Sec. 42	*July 1, 2007*	New section
Sec. 43	*July 1, 2007*	New section